Notification of Person in Need of Special Assistance

A qualified assessor who determines an individual with a Serious Mental Illness (SMI) is in need of Special Assistance (per ADHS/DBHS Policy & Procedures and Provider Manual and Title 9, Chapter 21 of the Arizona Administrative Code) must notify the Office of Human Rights within three (3) days of the determination at fax number 602-364-4590. The notification is required regardless of whether someone is already assisting the person to meet the Special Assistance needs.

Part A: Notification

The following person, **who is a person with an SMI**, is in need of Special Assistance to assist in participating effectively in the following (check all that apply, even if there is no pending discharge planning, grievance or appeal issue):

__ ISP Process

__ Discharge Planning Process If currently inpatient: _____
list inpatient facility

__ Grievance Process Grievance currently pending: ___ No ___ Yes: _____
docket # (if known)

__ Appeal Process Appeal currently pending: ___ No ___ Yes: _____
docket # (if known)

Name:_____ DOB: _____
Address: _____ Type of Residence:_____
City:_____ State:_____ Zip Code: _____ Phone:_____
Guardian (if none, list NA): _____
T/RBHA:_____ Provider Site:_____
Case Manager:_____ Clinical Supervisor:_____
Site Phone: _____ Site Fax: _____

Please provide the clinical basis for the assessment that the person is in need of Special Assistance. Detail the specific circumstances and how they affect the person's ability to participate effectively in the ISP, discharge planning, grievance/investigation, and/or appeal processes: _____
_____
_____
_____

Please indicate whether the person's Special Assistance needs are being addressed currently and by whom: __ No (see below) ___ Yes
Name: _____ Relationship:_____
Phone: _____ Address: _____

The person is not receiving assistance to meet his/her Special Assistance needs, so he/she is in need of an advocate being assigned for the following needs (check all that apply):

___ ISP ___ Grievance Process
___ Discharge Planning ___ Appeal Process

Is the person in need of Special Assistance aware that you are submitting this notification of Special Assistance? __ Yes __ No, please explain:_____

Date Completed: _____ By:_____
Name and Title

_____ _____
Phone Number Email Address

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PART B: Response from the Office of Human Rights (OHR)

Re: _____ Original Part A Notification Date:_____
List consumer name

Per the information submitted, the person meets necessary criteria for Special Assistance:
__ No: _____
_____
__ Yes: _____
_____
and the person's Special Assistance needs are (check all that apply):
___ ISP ___ Grievance Process
___ Discharge Planning ___ Appeal Process

The needs are being met by:
__ OHR: Assigned Advocate _____, as of _____
__ Other:_____
Name and Relationship
_____
Address and Phone Number

Date returned: _____ By:_____
Name and OHR Title

Additional information, if any:
_____
_____
_____
_____

Part C: Notification of Change

If a qualified assessor determines that the individual no longer needs Special Assistance, this section (on the original form) must be filled out and submitted to OHR within ten (10) days of the determination.

As of _____ (date), the above referenced person no longer meets the criteria to be in need of Special Assistance for the following reasons:_____
_____
_____
_____
I have informed the person that I am notifying OHR about the change in circumstances, and that the person no longer meets the criteria for a person in Need of Special Assistance. __ Yes __ No, please explain:_____

Date Completed: _____ By: _____
Name and Title Phone #